Increased Risk of Paroxysmal Atrial Fibrillation Episodes Associated with Acute Increases in Ambient Air Pollution

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OBJECTIVES: We reported previously that 24-hr moving average ambient air pollution concentrations were positively associated with ventricular arrhythmias detected by implantable cardioverter defibrillators (ICDs). ICDs also detect paroxysmal atrial fibrillation episodes (PAF) that result in rapid ventricular rates. In this same cohort of ICD patients, we assessed the association between ambient air pollution and episodes of PAF.

DESIGN: We performed a case–crossover study.

PARTICIPANTS: Patients who lived in the Boston, Massachusetts, metropolitan area and who had ICDs implanted between June 1995 and December 1999 (n = 203) were followed until July 2002.

EVALUATIONS/MEASUREMENTS: We used conditional logistic regression to explore the association between community air pollution and 91 electrophysiologist-confirmed episodes of PAF among 29 subjects.

RESULTS: We found a statistically significant positive association between episodes of PAF and increased ozone concentration (22 ppb) in the hour before the arrhythmia (odds ratio = 2.08; 95% confidence interval = 1.22, 3.54; p = 0.001). The risk estimate for a longer (24-hr) moving average was smaller, thus suggesting an immediate effect. Positive but not statistically significant associations were found for black carbon among patients with repeated events (Peters et al. 2000b). In a larger study of approximately 200 Boston-area ICD patients, we found a nonstatistically significant increase in risk of ventricular arrhythmias (confirmed by an electrophysiologist) associated with 2-day mean NO2, particulate matter < 2.5 µm in aerodynamic diameter (PM2.5), black carbon, carbon monoxide, ozone, and sulfur dioxide (Dockery et al. 2005a, 2005b). In a case–crossover analysis of these data, which allowed us to match the time of onset of these arrhythmias with ambient air pollution concentrations, we found stronger, statistically significant associations of ventricular arrhythmias with mean PM2.5 and O3 in the 24 hr before the arrhythmia (Rich et al. 2005).

Although ICDs are designed to detect and treat life-threatening ventricular arrhythmias, supraventricular arrhythmias may also be detected. Many of these supraventricular arrhythmias may be atrial fibrillation, which is the most common sustained arrhythmia in clinical practice (Go et al. 2001) and a risk factor for stroke (Prystowsky et al. 1996) and premature mortality (Kanel et al. 1983). We used a case–crossover design to examine the association of ICD-detected paroxysmal atrial fibrillation and hourly measurements of community air pollution concentrations.

Materials and Methods

Study population. Two hundred three patients who had a third-generation Guidant ICD (Cardiac Pacemakers, Inc., Minneapolis, MN) implanted at the Tufts–New England Medical Center between 1 June 1995 and 31 December 1999, were followed until their last clinic visit or early conversion following ventricular therapies associated with no ventricular electrogram, and lack of intracardiac electrogram before, during, and after episodes were recovered from the ICD. In a small number of cases in which the patient experienced a large number of ICD-detected episodes since the previous clinic visit, early electrograms in the ICD memory, but none of the other episode-specific data, may have been overwritten. ICD settings including ventricular tachycardia rate cutoffs (i.e., detection rates) were also abstracted from the ICD records. Ventricular tachycardia rate cutoffs were set by the treating electrophysiologist based on the clinical features of the patients.

All of the ICD-detected episodes were reviewed and characterized by an electrophysiologist (M.S.L) blinded to air pollution levels. Details of this arrhythmia classification have been published previously (Dockery et al. 2005b). Briefly, patients who presented with atrial fibrillation at all clinic follow-ups were classified as in permanent atrial fibrillation, and they were excluded from this analysis. Episodes of paroxysmal atrial fibrillation (PAF) were defined by a ventricular rate between 120 and 200 beats per minute, irregularity of the beat-to-beat intervals, no change in QRS morphology (except for a small number of cases with no ventricular electrogram), and lack of conversion following ventricular therapies that occurred during inpatient hospital visits were excluded. Further description of this population has been published previously (Dockery et al. 2005a, 2005b).

Outcome and clinical data. For each ICD-recorded episode of tachyarrhythmia, the date, time, beat-to-beat intervals, and intracardiac electrogram before, during, and after episodes were recovered from the ICD. In a small number of cases in which the patient experienced a large number of ICD-detected episodes since the previous clinic visit, early electrograms in the ICD memory, but none of the other episode-specific data, may have been overwritten. ICD settings including ventricular tachycardia rate cutoffs (i.e., detection rates) were also abstracted from the ICD records. Ventricular tachycardia rate cutoffs were set by the treating electrophysiologist based on the clinical features of the patients.

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Acute effect of pollutants. We analyzed the association of ambient air pollution concentrations and episodes of PAF using a case-crossover design (Maclure 1991). These methods have been used previously to study triggers of acute cardiovascular events (Albert et al. 2000; D’Ippoliti et al. 2003; Hallqvist et al. 2000; Mittleman et al. 1995; Peters et al. 2000a; Rich et al. 2005). In this design, each subject contributes information as a case during the event periods and as a matched control during nonevent times. Because cases and their matched controls are derived from the same person and a conditional analysis is conducted, non-time-varying potential confounders such as underlying medical condition and long-term smoking history are controlled by design. Variables that may be related to both air pollution and the occurrence of PAF that fluctuate over time (e.g., meteorologic conditions) are possible confounders.

We defined case periods by the detection time of each confirmed episode of PAF, rounded to the nearest hour. We matched control periods on weekday and hour of the day within the same calendar month (Lumley and Levy 2000). We calculated average pollution concentrations and weather conditions during the hour and during the 24 hours before the case and control time periods for this analysis.

Conditional logistic regression models, including the mean pollutant concentration in the hour of the arrhythmia (lag hour 0) and natural splines [3 degrees of freedom (df)] for the mean temperature, dew point, and barometric pressure in the 24 hr before the arrhythmia, were run separately for each pollutant (PM_{2.5}, black carbon, NO_{2}, CO, SO_{2} and O_{3}). Different individuals may have different cardiac responses to pollution, based on their clinical history and genetic characteristics. Therefore, we included a frailty term (Therneau and Grambsch 2000) for each subject (akin to a random intercept) in all the above models. Odds ratios (ORs), 95% confidence intervals (CIs), and p-values for statistical significance testing are presented for an interquartile range increase in each pollutant. We considered associations with longer exposures before the PAF episode using the mean of the pollutant in the previous 24 hr (lag hours 0–23).

To assess the sensitivity of our results to the influence of outliers, we reran analyses, trimming the highest 5% and lowest 5% of air pollution concentrations. For O_{3}, which has a strong seasonal pattern, we examined whether the association between PAF and O_{3} concentration was limited to the 6 months with the highest mean ambient temperature (May–October) by adding an O_{3}/warm month interaction term to the conditional logistic regression model. We assessed the linearity of the PAF and O_{3} association by replacing the linear air pollution term with a penalized spline (3 df) in the conditional logistic regression model. We plotted the covariate adjusted log OR for the risk of PAF in the spline and linear models versus 1-hr O_{3} concentration.

We used SAS (version 9.1; SAS Institute Inc., Cary, NC) software to construct all datasets and to calculate descriptive statistics. We used S-Plus 6.2 (Insightful Inc., Seattle, WA) software for all modeling.

Results

There were 203 ICD patients enrolled in the study who lived within 40 km of the Harvard School of Public Health with a mean (± SD) follow-up time of 3.1 ± 1.8 years (maximum = 7.0 years). Ninety-five patients had a total of 1,574 recorded ICD events, 933 of which were separated by > 1 hr. Ninety-one (9.8 %) of these events, among 29 subjects, were confirmed episodes of PAF. Because PM_{2.5} and black carbon were not measured during the entire study period, analyses of PM_{2.5} included at most 52 episodes of PAF from 22 subjects, and analyses of black carbon included at most 46 episodes of PAF from 18 subjects.

The 29 subjects with PAF episodes were primarily male (79%) and white (79%), and they ranged in age from 45 to 78 years (mean, 65 years). At their first clinic follow-up visit, 69% of subjects were listed as being prescribed beta-blockers, 57% digoxin, and 24% other antiarrhythmics (i.e., amiodarone, quinidine, sotalol, or mexilitine). Two subjects (7%) were not prescribed any of these medications. The most common diagnoses at implantation were coronary artery disease (76%) and idiopathic cardiomyopathy (22%). Before ICD implantation, 55% of subjects had left ventricular ejection fractions < 35%. Subjects’ ICDs were programmed with ventricular tachycardia detection rates (i.e., ventricular rate threshold above which the electrogram and date/time for a tachycardia would be recorded) that had a 10th to 90th percentile range of 140 to 200 beats/min (median = 175).

Of the 29 subjects who experienced at least one episode of PAF, 15 (52%) experienced > 1 event, while 2 (7%) experienced ≥ 10. Twenty (69%) also experienced a ventricular arrhythmia during follow-up. Episodes of PAF were more frequent in the late morning (0900–1100 hr), with a smaller evening peak (1800–2000 hr).

The distributions of air pollution concentrations and meteorologic characteristics in Boston during the study period, averaged hourly and daily, are summarized in Table 1. The highest average PM_{2.5} and black carbon concentrations were observed early in the morning (0600–0800 hr), highest NO_{2} in the early morning (0600–0800 hr) and early evening (1600–2100 hr), and highest O_{3} at midday (1200–1400 hr). Further detail has been provided previously (Dockery et al. 2005b).

We found a statistically significant increased risk of PAF associated with mean O_{3} concentration in the concurrent hour (lag hour 0; Table 2). The estimated relative odds for the 24-hr moving average concentration was positive (OR > 1), but not statistically significant. We did not find statistically significant associations with any other pollutant in the concurrent hour, but associations were positive for PM_{2.5} and NO_{2}. Risk estimates for 24-hr average PM_{2.5}, NO_{2}, and black carbon were positive, but none was statistically significant. Risk estimates for 24-hr average CO and SO_{2} were protective (OR < 1), but neither was statistically significant (Table 2).

For O_{3} in the concurrent hour, there was little change in risk of PAF when we excluded the top 5% and bottom 5% of concentrations (OR = 2.15, 95% CI = 1.04–4.44, p = 0.04). The association between PAF and O_{3} in the concurrent hour in the cold months (OR = 2.21; 95% CI = 0.98–4.98; p = 0.06) was
Figure 1 shows the covariate adjusted log OR for the risk of PAF versus 1-hr O3 concentration modeled using first a linear term and then a penalized spline (3 df). We found no evidence of a deviation from linearity (nonlinear term, p = 0.63).

**Discussion**

In a study designed to assess the association of ambient air pollution with ventricular arrhythmias among ICD patients, a unique opportunity to assess associations between air pollution and episodes of PAF. Although these episodes of PAF were likely an underrepresentation of all those PAF episodes experienced by these patients, they provided a comparable to that in the warm months (OR = 1.98; 95% CI = 1.05–3.73; p = 0.04), with no significant interaction (p = 0.84).

Our findings identify ambient air pollution as a potential precipitant of supraventricular arrhythmias. Atrial fibrillation is the most common supraventricular arrhythmia. Atrial fibrillation doubles with each decade of adult life (Falk 2001). Although atrial fibrillation is not usually considered a lethal rhythm, it is associated with premature mortality and increased risk for hospitalization and stroke (Wolfe et al. 1998; Benjamin et al. 1998). If not on antithrombotic therapy, people with atrial fibrillation have a 5-fold increased risk of stroke (Ryder and Benjamin 1999). Therefore, even a modest risk of atrial fibrillation associated with acute exposure to elevated ambient air pollution in the general population would have a substantial attributable risk.

In prior analyses in this cohort of ICD patients, we found significantly increased risk of ventricular arrhythmias associated with mean PM2.5 and O3 concentrations in the 24 hr before the episode (Rich et al. 2005), and marginally significant increased risk in each 7-μg/m3 increase in ambient PM10 (particulate matter < 10 μm in aerodynamic diameter) concentration in a panel of chronic obstructive pulmonary disease patients (Brauer et al. 2001). They reported smaller increases in supraventricular ectopy associated with outdoor and personal PM2.5 and sulfates.
by photochemical reactions in the atmosphere. O₃ concentrations are highest on warm sunny days, and highest during the afternoon hours. However, we found a statistically significant association with O₃ after adjustment for temperature, and we found no evidence that the O₃ associations were restricted to the six warmest months.

We also found positive associations with PM₂.₅, NO₂, and black carbon, but the CIs were wide and the risk estimates were not statistically significant. The number of PAF episodes with matching O₃ and NO₂ concentrations was small (n = 90), and they were even smaller for PM₂.₅ (n = 52) and black carbon (n = 46), which resulted in reduced power to detect any associations. Thus, this small number of confirmed PAF episodes dictates caution in our interpretation of specific associations. Although we have highlighted the association with O₃ in the concurrent hour, it would be premature to attribute the increased risk of PAF to O₃ alone. We suggest that community air pollution may be associated with the incidence of PAF. Confirmation of this association and examination of associations with specific pollutants requires a larger number of confirmed PAF episodes.

A problem in studying incidence of PAF is the definition of time of onset of new episodes. Although the ICD device provides a detection method for each episode of PAF, this is the time the ventricular rate (responding to the atrial stimulus) exceeded the patient’s specific programmed criteria for a tachyarrhythmia. The PAF episode may have started earlier than the time recorded by the ICD. This situation would lead to mismatching of air pollution concentrations to case and control time periods. However, this exposure misclassification would be nondifferential with respect to case/control status. Therefore, it would have resulted in a bias toward the null, underestimates of risk, and wide CIs.

Episodes of PAF also may have been misclassified. However, any outcome misclassification, if present, was likely independent of air pollution levels and nondifferential. This misclassification would have produced wider CIs, a bias toward the null, and underestimates of risk.

Our analysis was limited to a subset of all PAF episodes that these subjects experienced. PAF episodes with ventricular response rates that remained below the ICD’s preset detection criteria for the duration of the arrhythmia would not have been recorded. These under-detected episodes likely represented a substantial fraction of the PAF episodes experienced by these patients. However, we used the case–crossover method, where each person serves as his or her own control, and event times are contrasted with matched control times. Such misclassification would have resulted in a loss of power, but no bias in our risk estimates. Whether our finding of an association between transient ambient air pollution concentrations and PAF is limited to this particular subset of PAF episodes, however, is unknown. Studies using devices programmed to detect a wider range of PAF episodes with more precise data on the timing of arrhythmia initiation are required to confirm and quantify this association further.

**References**


